POLICY TITLE: CHILD FATALITY REVIEW CHAPTER:		PAGE 1 OF 15
	CHILD AND FAMILY SERVICES AGENCY **Approved by:**_____ Signature of Agency Director	PROFESSIONAL STANDARDS
EFFECTIVE DATE:	LATEST REVISION: March 18, 2009	APPROVED BY LEGAL COUNSEL: March 8, 2009

I. AUTHORITY	All applicable federal and District of Columbia laws, rules, and regulations, including DC Official Code § 4-1371.01 *et seq.)* (2006 Supp.), the LaShawn Modified Final Order (November 18, 1983), and the *LaShawn A. v. Fenty* Amended Implementation Plan (February 2007).
II. APPLICABILITY	All agency employees, contract agency staff and contracted personnel.
III. RATIONALE	It is the mission of the Child and Family Services Agency (CFSA) to promote the safety, permanence and well-being of children and families in the District of Columbia. The Modified Final Order, Implementation Plan, Amended Implementation Plan and District law require CFSA to review the circumstances surrounding child deaths in situations where the child and/or family were known to the agency within 4 years of the child's death and to identify systemic issues to prevent future child deaths. CFSA employs an internal Child Fatality Review process with the goal of reducing the number of preventable child deaths. The Child Fatality Review process shall provide the Agency with a continuous learning model as it strengthens case practice. An internal Child Fatality Review (CFR) Committee reviews the fatalities of children whose family was known to the Agency within 4 years prior to the child's death. The CFR Committee is comprised of Agency stakeholders from all levels and disciplines (staff such as administrators, program managers, supervisors, and social workers, attorneys, etc.) and external stakeholders (the federal Court Monitor, citizen and city-wide child fatality review committee members and others). The CFR Committee makes recommendations to improve outcomes for children and families. These recommendations may pertain to general system improvements to service delivery, to refining and/or developing new policies and procedures, to assessment of training needs, and/or to strengthening current case practice.

IV. POLICY	CFSA shall review and analyze any death of a child currently known or who has been known to the Agency within 4 years prior to the child's death. The Child Fatality Review Unit and the internal CFR Committee shall review instances in which there has been a child death to make recommendations on changes in case practice and for overall systemic change. Recommendations to change Agency policy and practice shall be reported to the CFSA director and implemented as appropriate. CFSA shall conduct a comprehensive review and analysis of the circumstances surrounding each child death and review of the overall quality of Agency case practice and performance on behalf of the family of the child and family. When information about the cause and manner of death is not known by the time of the internal review, the circumstances around the child's death will not be included as a part of the discussion of preventability. The discussion will then focus on case practice and on any risk factors identified. *Note: All media inquiries regarding the death of a child shall be directed to the CFSA Office of Public Information. No CFSA staff or staff of a private provider may discuss the child's death or any relevant details with the media until authorized to do so.*
V. CONTENTS	**A.** Notification of Child Fatality **B.** Investigation and Assessment **C.** Services Provided to the Family of the Deceased Child **D.** Funeral Arrangements and Assistance with Burial or Cremation Expenses **E.** Support for Social Workers **F.** Child Fatality Critical Event Meeting **G.** Internal Child Fatality Review Process **H.** Recommendations and Accountability **I.** City-wide Child Fatality Review **J.** Training **K.** Records Management
VI. PROCEDURES	**Procedure A: Notification of Child Fatality** The notification process begins immediately upon CFSA or private agency staff learning of a child's death. When an employee of CFSA or a private agency is notified of a child's death the following procedures must be followed to ensure timely and appropriate response. **A CFSA or a private agency staff member shall immediately (within 30 minutes of notification) report the death of the child to the Hotline (202) 671–SAFE.** Requirements for Hotline Staff 1. Upon receiving the report of the child's death, the Hotline worker shall immediately enter the information contained in the report of the death into FACES as a child fatality. (See the Hotline policy for description of

information to be entered into FACES.)

a. If allegations of abuse and/or neglect are present (for an active case, a closed case, or for a child with whom CFSA has had no prior contact), the information shall be entered into FACES.NET as an Investigation requiring an immediate response.
b. If there are no allegations of abuse or neglect (for a closed case or for a child with whom CFSA has had no prior contact), the information shall be entered as an Information & Referral (I&R).

2. For reports entered as I&Rs, the Hotline worker shall forward the reports to the Child Protective Services (CPS) administrator and the Child Fatality Review Unit.

3. For reports entered as Investigations, the Hotline worker shall complete the Critical Event Summary/Update Form (*see Critical Events policy*) and shall forward the reports to the Special Abuse Unit.

4. For reports where the death refers to a child who is the subject of a closed case, the Hotline worker shall enter the information into FACES.NET. The screen will automatically fill in the Agency's involvement with the family before the case was closed.

5. The Hotline worker shall forward all reports of child fatalities to the Metropolitan Police Department (MPD) Youth Investigations Branch (YIB) unless the MPD YIB was the originator of the report (*see Investigations policy*).

Requirements for Child Protective Services

1. Upon receipt of the report of the death, the CPS program administrator shall notify the CFSA director of the child's death within 2 hours for any child whose family is involved in an open case or where CPS has opened an investigation, and within 6 hours for children in closed cases or those unknown to the Agency.

2. The Hotline supervisor shall notify the following persons in writing (i.e., via Critical Event Report or via e-mail):
   a. Director
   b. Assigned social worker (or last known social worker), if applicable
   c. Unit supervisor, program manager, and program administrator (if applicable)
   d. Deputy director for Agency Programs
   e. Deputy director for the Office of Planning, Policy, and Program Support
   f. Deputy director for the Office of Clinical Practice
   g. Quality Assurance program manager
   h. Child Fatality Review supervisor
   i. Administrator for the Contract Monitoring and Performance Improvement Administration
   j. General counsel

	k. Office of Public Information l. Medical director m. Director of LaShawn Accountability n. Family Team Meeting program manager o. Other designated persons 3. In the event of a death of a child in an open case or active investigation, the program administrator for that program shall ensure that the assigned social worker and supervisor receive a face-to-face notification, or verbal notification if face-to-face notification is not practical. 4. If it is determined by CPS that the death refers to a child who is the subject of a closed case, the CPS social worker shall notify, either face-to-face or by email, the last known assigned social worker, supervisor, program manager, and program administrator. <u>Requirements for Assigned Social Worker</u> 1. The assigned social worker and/or the supervisor shall immediately (within 1 hour of notification) notify the following persons of the child's death: a. The child's biological parent(s) (if applicable) • Efforts to locate biological parents shall include contact with neighbors, schools, the Court, the Diligent Search Unit, MPD, etc. If the parent(s) cannot be located, the assigned social worker shall notify other family members of the child's death. b. The child's foster parent(s) (if applicable) c. The assigned assistant attorney general (AAG) and guardian *ad litem* (GAL) (if Court involved) d. All other CFSA staff and private agency providers currently involved with the family e. The CFSA public information officer *Note: if the notification of the child fatality did not originate with the Hotline staff, the assigned social worker or supervisor shall notify the Hotline of the child fatality.* <u>Office of the Assistant Attorney General</u> • If the active case is Court involved, the AAG will file a "suggestion of death" notice with the Court within 24 hours of notification.
	Procedure B: Investigation and Assessment <u>Requirements for Child Protective Services</u>

1. Should the report result in an investigation, the CPS social worker shall investigate the report in accordance with District law and CFSA *Investigations policy*.

2. The CPS social worker shall be dispatched immediately to the home to verify the death, and to assess the safety of all children under 18 years of age remaining in the home (if applicable).

3. Children who may be a part of the family, but do not reside in the same home as the deceased, must also be contacted and a safety assessment conducted within 24 hours (if residing in the metropolitan District of Columbia area). (*See Investigations policy.)*

Requirements for Assigned Social Worker

1. The assigned social worker shall assess the immediate needs of the family and assist with service provision. *(See Procedure C.)*

2. If the child's death is alleged to have been caused by abuse or neglect, the assigned social worker shall work cooperatively with CPS staff to facilitate the investigation of the fatality.

3. The assigned social worker shall make available all requested case record information to the Child Fatality Review Unit within 48 hours of notification of the child fatality and be an active participant in the internal child fatality review.

4. The supervisor shall support the assigned social worker in meeting the immediate needs of the family and assist the social worker in meeting all required timeframes in the investigation of the fatality (when applicable) and/or other requirements (i.e., notification to the Court).

Requirements for Private Agency Staff

1. If the child was placed in foster care, a congregate care or other facility with a private agency at the time of death, the private agency social worker shall coordinate with the staff of the Contract Monitoring and Performance Improvement Administration to assess the foster home or facility for compliance with licensing rules and applicable contract requirements. The assessment shall be completed in cooperation with the Institutional Investigations staff.

2. The Contract Monitoring and Performance Improvement Administration staff shall take any required action(s) as a result of the assessment and in accordance with CFSA policy.

3. The private agency staff shall conduct an internal inquiry of the circumstances of the child's death and issue a report on the findings. The private agency staff shall forward the report to the respective CFSA program monitor within 24 hours of notification of the death. The program monitor shall forward the findings report to the Child Fatality Review Unit Supervisor, to be incorporated in CFSA's internal review process.

Procedure C: Services Provided to the Family of the Deceased Child

When reviewing the circumstances surrounding the death of a child, CFSA is committed to ensuring the safety and well-being of all children who remain in the home and to meeting the immediate needs of the family. The needs and desires of the family should guide the actions of the social worker once the safety of the other children has been assessed.

1. The CPS social worker shall coordinate the initial visit when more than one CFSA social worker (including private agency social workers) is involved with the case. The assigned social worker and/or the supervisor shall visit the family of the deceased child within 24 hours of notification of the death (in the foster home and/or birth family's home as indicated).

2. A comprehensive assessment of the family's needs and appropriate supportive services shall be conducted.

3. The assigned social worker and supervisor shall offer assistance to the parents, guardians, and foster parents (if applicable).

    a. Assistance shall include management of emotional issues, grief counseling, assistance with burial arrangements, and any other necessary services. (*See Procedure D below.)*

    b. If there are other District agencies or private entities involved with the family who are also in the home to offer or provide assistance, CFSA or private agency social workers shall consult with their supervisor to determine what coordinating role, if any, the CFSA social worker should have.

4. If the death is of a child who is the subject of a closed case or a child who was not known to CFSA, the CPS social worker may advise families to contact the Department of Human Services - Income Maintenance Administration (IMA) Burial Assistance Program, the Mayor's Constituent Services Office, Crime Victims Compensation Program, or one of the Healthy Families Thriving Communities Collaboratives for assistance with supportive services related to the child's death.

Procedure D: Funeral Arrangements and Assistance with Burial or Cremation Expenses

This procedure offers guidance to CFSA staff, private agency staff, birth parents and foster parents regarding funeral arrangements and assistance with burial expenses in the event of the death of a child receiving services in their own home or in out-of-home placement.

1. **<u>General Expectations of Social Workers</u>**

    a. Social workers are expected to work with the deceased child's family and resource family (if applicable) to assist in making funeral arrangements to the extent that the family chooses to work with the social worker. Social workers shall make attempts and give priority to honoring the family's preferences when possible.

    b. The social worker most recently involved with the case is generally

expected to take the lead in assessing the need for grief counseling and to offer the referral for those services, if desired by the family and/or resource family (if applicable), through the Office of Clinical Practice.

c. All information pertaining to services and assistance provided by CFSA shall be documented in FACES.NET and copies of relevant documents maintained in the hard copy case file.

2. **Children in Out-of-Home Placement**

a. If parental rights have not been terminated, a parent must sign all official documents (i.e., death certificates and hospital release forms). If the parents are unable to be located, the deputy director for Program Operations and the general counsel shall be contacted to determine how to proceed.

b. CFSA may provide up to $5000 to cover the requested funeral expenses of children with the legal status of committed, in shelter care, or children who are in the Agency's custody**.**

c. CFSA's financial assistance (as described in "b" above) shall also cover costs associated with burial or cremation expenses. If there are unusual circumstances, the assigned social worker should consult the deputy director for Program Operations regarding special conditions requiring alternative funeral arrangements. When requesting funds the social worker must submit a memorandum that shall include the following information:

i. Name of the child

ii. CFSA case identification number

iii. Legal status of the child at the time of death

iv. Date and time of funeral service if known

v. Name and address of the funeral home providing funeral services

vi. An itemized list of all services being provided

vii. The amount of the request

viii. A copy of the purchase order/invoice from the vendor

d. The memorandum must be reviewed and approved by the program administrator and the deputy director for Agency Programs.

e. The social worker or supervisor shall ensure that the approved memorandum is forwarded to Fiscal Operations for processing of the payment. Fiscal Operations is responsible for a timely response and preparation of the payment within 24 hours or 1 business day.

f. Private agency social workers shall submit a memorandum requesting financial assistance to the program monitor within 24 hours or 1 business day of notification for approval. The program monitor shall forward a copy of the memorandum to the deputy director for Program Operations within 24 hours of receipt.

g. All of the deceased's personal effects shall be returned to the family.

If parental rights have been terminated or the family cannot be located the Agency shall make a determination regarding disposal of all items.

3. <u>Resources for Families</u>

a. Department of Human Services-Income Maintenance Administration (IMA) Burial Assistance Program

i. Children Receiving Services While Residing in Their Own Home

For families of children receiving services while residing in their own home, the CFSA social worker shall refer the family to the Department of Human Services, Income Maintenance Administration (IMA) Burial Assistance Program (202.698.4112). Financial assistance of up to $800 towards the cost of a funeral or up to $450 towards the cost of cremation may be offered to the family. These families are not eligible for the CFSA assistance for funerals. For any assistance not covered through the Burial Assistance Program, CFSA shall provide the remaining assistance through demand payment (up to the IMA program limits).

ii. **Children in Out-of-Home Care**

For families whose children are in out-of-home care and their parental rights have not been terminated, the assigned social worker shall explain the IMA Burial Assistance program to the families (low-income District residents are eligible for the program). For any assistance not covered through the Burial Assistance Program, CFSA shall provide the remaining assistance through demand payment (up to the CFSA program limit).

b. **Crime Victims Compensation Program**

If the child's death is caused by violent crime, the family of the deceased child will be advised to access financial assistance through the MPD's Crime Victims Compensation Program (CVCP), in lieu of financial assistance through CFSA.

i. To access assistance through the CVCP, the death must have occurred within the District of Columbia or as a result of a terrorist act or mass violence outside of the United States.

ii. The CVCP pays for bills not covered by collateral sources (i.e., private health, life, or automobile insurance, medical aid programs, and Social Security income or disability).

iii. Coverage may not exceed $25,000 per claim with a maximum of $3,000 for funeral expenses.

iv. Additional information and/or applications may be obtained by contacting the CVCP office at 202-879-4216 or www.dccourts.gov.

	Procedure E: Support for Social Workers Death and loss may have a traumatic impact on a social worker currently or previously involved with the deceased child or their family. 1. The supervisor, program manager or program administrator shall provide emotional support to the social workers during this process. 2. Grief counseling and other supportive services, such as administrative leave, shall be made available to the social worker. 3. Social workers may access services through the District Government's Employee Assistance Program (EAP).
	Procedure F: Child Fatality Critical Event Meeting A Critical Event meeting should occur within 24 hours of the Child Fatality Review supervisor being notified of the child's death. This meeting shall serve as a forum to gather and coordinate information regarding the case, provide direction on immediate case activities, inform the investigation process, and to provide a mechanism for support to the family and the assigned social worker when applicable. 1. Upon notification by the CPS supervisor, the Child Fatality Review supervisor shall schedule a Critical Event meeting and assign a Child Fatality Review specialist to the case. Meeting participants may include but are not limited to the following individuals: a. Director b. Deputy director for Agency Programs c. Deputy director for the Office of Clinical Practice d. Public information officer e. Risk manager f. Director for LaShawn Accountability g. General counsel or designee h. Child Protective Services administrator i. Contract Monitoring and Performance Improvement Administrator j. Clinical director, Office of Clinical Practice k. Medical director, Office of Clinical Practice l. Quality Assurance program manager m. Child Fatality Review supervisor n. Child Fatality Review specialist o. Current Child Protective Services social worker p. Assigned social worker, supervisor, program manager, and program administrator (if applicable)

q. Private agency social work team (if applicable)

r. Other staff as appropriate.

2. Within 2 days of the Critical Event meeting, the Child Fatality Review specialist shall prepare a summary report of the meeting, including any recommended next steps and forward to relevant parties for implementation purposes.

3. The Child Fatality Review specialist or designee shall follow up with the necessary parties prior to the internal Child Fatality Review meeting to determine the status of the recommended steps from the Critical Event meeting.

   - If the actions or next steps have not been completed, the Child Fatality Specialist shall immediately notify the Child Fatality Review Program Manager who will discuss the status with the appropriate Program Administrator.

4. If the case is open, or the child and family are known to CFSA within 4 years of the date of the child's death, the case shall be scheduled for an internal Child Fatality Review meeting.

Procedure G: Internal Child Fatality Review Process

The Child Fatality Review Unit shall conduct a comprehensive review of the cases (for all causes, including natural death, death as a result of abuse or neglect, homicide, etc.) for all children known to CFSA within 4 years prior to the child's death. The Child Fatality Review specialist shall prepare a written Child Fatality Report that includes the information gathered from the comprehensive reviews and the history of how CFSA served the decedent and his or her family since the case was known to the Agency.

If the City-wide Child Fatality Review Committee notifies the Child Fatality Unit supervisor or designee of deaths of children and youth in the District, the Child Fatality Review Unit supervisor shall make an assessment of each notification by reviewing CFSA records, documents, and databases including FACES. If the death is of a child or youth currently known to CFSA or has been known to the Agency within 4 years prior to the death, the Child Fatality Review Unit supervisor shall assign the case to a Child Fatality Review specialist. The Child Fatality Review supervisor shall schedule the internal review to be held within 45 days of the determination that the child is or was known to CFSA.

1. Attendance at the Child Fatality reviews is principally limited to the following participants:

   a. Deputy director, Office of Clinical Practice

   b. Deputy director, Office of Planning, Policy and Program Support or designee

   c. Deputy director for Agency Programs or designee

   d. Quality Assurance program manager

   e. Child Fatality Review supervisor

f. Director for LaShawn Accountability

g. Program administrators and program managers associated with the case and family

h. Supervisors associated with the case and family

i. Social workers associated with the case and family

j. Child Protective Services social workers associated with the case and family

k. Contract Monitoring and Performance Improvement administrator

l. Training administrator

m. Family Team Meeting program manager, as applicable

n. General counsel or designee

o. Assistant attorney general or designee

p. CFSA Court Monitor or designee

q. City-wide Child Fatality Review program manager

r. Community representative

s. Collaborative representative, as applicable

Note: under no circumstances shall staff invite others to attend the internal review without authorization from the Child Fatality Review supervisor.

<u>Preparation for Internal Review Meeting</u>

1. The social worker or the supervisor assigned to the child's case shall provide ongoing consultation to the Child Fatality Review specialist throughout the process of reviewing the child fatality.

2. The social worker or the supervisor assigned to the child's case shall review the hard copy case files and electronic records in FACES.NET.

3. The Child Fatality Review specialist shall complete the following tasks:

   a. Review the circumstances surrounding the child's death.

   b. Research the nature of CFSA and/or private provider involvement with the child and his/her family through a review of information in FACES.NET.

   c. Review hard copy records.

   d. Conduct interviews with relevant parties.

   e. Prepare the Child Fatality Report for the members of the internal CFR Committee.

<u>Written Report for Internal Review Meeting</u>

1. The written Child Fatality Report shall address the following questions to determine the specific strengths and challenges with regard to Agency practices, the lessons learned, service delivery, policy and training:

   a. Did CFSA take every reasonable action and make every reasonable effort to ensure the safety of the child and other

children in the household? Describe in detail.

b. What are the practice, training or policy issues that need to be resolved as it relates to the respective child fatality?

c. What systemic issues such as supervision, staffing, access to records, etc. need to be resolved?

d. What were the parental or familial behavior factors that contributed to the fatality?

e. Given all of the information available now, what steps or actions would be done differently?

f. What are the interagency issues to present to the City-wide Child Fatality Review Committee?

2. Child Fatality Reports shall be written to reflect the case activity with regard to the standard questions (see above). The focus of the reports will be information that identifies risk factors that may have contributed to the fatality, the strengths, and case specific as well as internal agency issues impacting the child fatality or services provided for the family.

   a. When a child fatality referral is received for a child who is the subject of a closed CFSA case, the Child Fatality Report shall address the Agency's involvement with the family before the case was closed.

   b. The Report shall address the circumstances under which the case was closed, including the whereabouts of all children in the family at the time of case closure.

3. All participants shall receive the draft child fatality report 3 business days prior to the scheduled internal review.

<u>Internal Review Meeting</u>

1. All participants shall sign a confidentiality agreement, provided by the Child Fatality Review Unit.

2. The supervisor assigned to the child's case and/or program manager are responsible for responding to any concerns raised in the Child Fatality Report, including but not limited to practice issues, resource needs, and systems barriers.

3. During reviews, the internal CFR Committee shall examine the circumstances surrounding the death and identify risk factors that may have contributed to the death.

4. After reviewing the contributing factors, the internal CFR Committee shall determine what risk factors may have contributed to the fatality. "Preventability" is not to be equated with an attribution of blame, but reflects an identification of risk factors. Preventability will be assessed based on three categories:

   a. More likely preventable: when the risk factors leading to the fatality are identifiable

   b. Less likely preventable: when the risk factors may be identifiable

but not attributable to the fatality

c. Not likely preventable: when there are no identifiable risk factors known that are attributable to the fatality

Note: Child Fatality Preventability Determination - preventability refers to identifiable risk factors that an individual or community could have influenced to change the circumstances surrounding the child's death. Examples may include, but are not limited to, co-sleeping, access to firearms, medical, etc.

Procedure H: Recommendations and Accountability

Recommendations from the internal child fatality review meetings are generated for the purpose of improving engagement, practice with families and service delivery, improving processes for accountability of CFSA and private agency staff involved with families, and for establishing a more responsive child welfare system that reduces the incidence of unexpected and preventable child deaths.

1. Recommendations shall be recorded and tracked by the Child Fatality Review Unit staff. Recommendations may come in the form of verbal feedback during the meetings or in writing via the Child Fatality Review recommendation form provided at the meeting. When necessary, the Child Fatality Review Unit staff shall seek clarification regarding each recommendation to ensure that each is clear and specific enough for implementation and accountability purposes.

2. Persons responsible for following up on a particular recommendation shall be identified during the meeting by the internal child fatality review meeting participants and a list of recommendations for each meeting shall be recorded and tracked.

3. One week following the internal child fatality review meeting, the Child Fatality Review specialist shall complete a summary report which includes a brief summary of the case history, circumstances surrounding the child's death when known, major issues discussed during the review, and recommendations generated from the review.

4. The summary report and list of recommendations generated from the internal child fatality review meeting shall be forwarded by the Child Fatality Review Unit staff to the CFSA director and the program administrator or deputy director responsible for the implementation of the recommendation.

   a. The summary report and list shall be forwarded 1 week following the date of the internal child fatality review meeting.

   b. The recommendations shall be tied to the continuous quality improvement processes within CFSA to ensure that implementation of the recommendations lead to improved practice.

	5. The program administrator or deputy director is responsible for reviewing the recommendations from the internal child fatality review meeting. These recommendations may pertain to practice, training, system, or other issues that were identified during the review process. Within 2 weeks of receipt of the recommendations, the program administrator or deputy director shall indicate to the Child Fatality Review Unit his/her plans to implement the recommendations using the recommendation format provided by the Child Fatality Review Unit. a. If the program administrator or deputy director disagrees with a particular recommendation s/he shall indicate his/her response in writing using the same recommendation format. b. The program administrator or deputy director may delegate tasks but they are ultimately responsible for assuring that recommendations are appropriately reviewed and implemented. 6. The program administrator or deputy director (or designee) shall within 30 days of receiving the recommendations develop and submit to the Child Fatality Review Unit, a formal strategy/work plan for addressing the recommendations and issues. 7. The Child Fatality Review Unit shall work closely with the responsible parties to track and ensure progress towards implementation of recommendations and program improvement strategies. 8. The Child Fatality Review Unit shall submit a quarterly report to the director and deputy directors that shall include a status report that highlights progress towards the implementation of each recommendation and the implementation of the work plan. • The status reports shall also address any barriers and systemic issues that may have led to delays or oversights, as well as those that enhance and inform case practice, training, policy development, and system reforms. 9. Recommendations and Agency reforms resulting from the recommendations shall be incorporated into the Annual Child Fatality Review Report and made available to the public. This Report shall be submitted to the City-wide Child Fatality Review program manager.
	Procedure I: City-wide Child Fatality Review The District of Columbia Child Fatality Review Committee was established by the Child Fatality Review Committee Establishment Act of 2001 (Title XLVI of DC Law 14-28, effective October 3, 2001; DC Official Code § 4-1371.01 *et seq.)* (2006 Supp.). CFSA is committed to working in collaboration with the City-wide committee to maximize the benefits of the review process. 1. The internal Child Fatality Review supervisor shall coordinate CFSA child fatality review activities with the City-wide Child Fatality Review program manager. This shall include the sharing of all relevant

	information, data, and case files of the deceased child and family. 2. The CFSA director or designee shall represent the Agency on the City-wide Child Fatality Review Committee.
	Procedure J: Training Training shall be provided to Agency staff on the child fatality review process and on other training topics, to include how to address grief and loss issues with families, how to respond to child fatalities, and any other topic or issue identified by the internal CFR Committee. Training may be provided internally by CFSA or by an external organization.
	Procedure K: Records Management 1. The Child Fatality Review supervisor shall ensure that all electronic internal child fatality review reports are maintained on a secure drive and shall not be destroyed. 2. All Child Fatality Review final reports shall be retained electronically. The hard copy shall be destroyed 4 years from the completion date of the report. 3. Data collection records (participant lists, surveys, interview notes, etc.) shall be retained and destroyed 2 years from the completion of the final report.